

# Tulare County 2015 Health Plan Enrollment Form

## ACTIVE EMPLOYEES

New Hire <input type="checkbox"/>				Open Enrollment <input type="checkbox"/>				Effective Date: _____			
Last Name: _____			First Name: _____			MI: _____		Employee ID#: _____		Social Security #: _____	
Address: _____					Phone Number: _____			Date of Birth: _____		Gender: _____	
<b>Health Plan Options</b> <b>Includes Medical, Vision, Dental &amp; Prescription</b>											
<b>A. Medical Plans (Select One)</b>								<b>C. Coverage Level</b>			
<input type="checkbox"/> 1. Anthem Blue Cross HMO (Must select Primary Care Physician)								<input type="checkbox"/> Employee Only			
<input type="checkbox"/> 2. Anthem Blue Cross \$0 Deductible PPO Plan								<input type="checkbox"/> Employee + Spouse			
<input type="checkbox"/> 3. Anthem Blue Cross \$500 Deductible PPO Plan								<input type="checkbox"/> Employee + Child(ren)			
<input type="checkbox"/> 4. Anthem Blue Cross \$1000 Deductible PPO Plan								<input type="checkbox"/> Employee + Family			
<input type="checkbox"/> 5. Anthem Blue Cross \$2500 High Deductible PPO Plan*						<input type="checkbox"/> *Health Savings Account Amount \$ _____		<b>D. Members Enrolling</b>			
<input type="checkbox"/> 6. Kaiser Permanente HMO Deductible Plan						Group # _____					
<input type="checkbox"/> 7. Kaiser Permanente HMO Traditional Plan						Enrollment Unit # _____					
<b>B. Dental Plans (Select One)</b>											
<input type="checkbox"/> 1. Delta Dental PPO											
<input type="checkbox"/> 2. DeltaCare USA HMO											
Are you now or have you ever been a Kaiser Permanente member: <input type="checkbox"/> NO <input type="checkbox"/> YES Kaiser Medical Record # _____											
Dependent(s) Name:				Relationship:		Date of Birth:		Social Security #:		Gender:	
1										<input type="checkbox"/>	
2										<input type="checkbox"/>	
3										<input type="checkbox"/>	
4										<input type="checkbox"/>	
<input type="checkbox"/> I understand that I will be required to provide documentation that verifies the relationship of any dependent(s) I enroll on the plan.											
<b>MEDICARE:</b> Do you or any of your dependents have Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES - If yes, please provide a copy of your Medicare Card(s). <b>YOU:</b> <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> BOTH Effective Date: _____ Eligibility Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD <b>DEPENDENT:</b> <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> BOTH Effective Date: _____ Eligibility Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD											
I understand that as a participant in the TULARE COUNTY Flexible Benefit Plan, my plan selections are effective on the eligible date of enrollment through December 31, 2015, and <b>cannot</b> be changed until Open Enrollment. Dependent deletions and additions can only be made during the plan year if I have a qualifying family status change as defined in IRS regulations and the COUNTY OF TULARE Flexible Benefit Plan as events such as, but not limited to, death, divorce, birth or adoption of a child, marriage, or change in spouse's employment. Qualifying family status changes <b>must be reported within 30 days of the event and accompanied by the appropriate documentation.</b> I also understand that any contribution I am required to make for my benefit selections will be taken from my earnings prior to the deduction of payroll taxes as allowed by State and Federal laws.											
I have read and understand the binding arbitration and plan disclosure information printed on the reverse side of this form. I understand my acceptance of these provisions is a requirement to enroll in the health plan. My signature below indicates my agreement to the terms and conditions required by the insurance carriers.											
All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.											
Participant Signature: _____										Date: _____	
<b>For Office Use Only:</b> Employee ID# _____ BU _____ Hire Date: _____ Coverage Eff Date: _____ PR Ded / Ben Amt Date: _____ Keyed AdmDir Date: _____ By _____											

## DISCLOSURE INFORMATION



### **Kaiser Foundation Health Plan Arbitration Agreement**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

\_\_\_\_\_  
Signature Required for Kaiser Permanente Plan

\_\_\_\_\_  
Date



### **ANTHEM BLUE CROSS BINDING ARBITRATION AGREEMENT**

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_